“It was fry or jump, so I jumped…” said Andy Mochan, describing his tale of survivorship during a massive oil rig explosion off the coast of Scotland. Sadly, the majority perished that evening, hanging on to the familiarity of the platform (Figure 1). Amidst the flames, Andy Mochan leaped into the frigidly cold ocean 15 stories below him, choosing possible death over certain death. This “burning platform” is the ideal allegory to the insight that unless people are faced with a compelling reason to change, they will hold on to the status quo with tenacity, regardless of whether the status quo is perceived as positive or negative.

Indeed, human nature is to be stagnant and to embellish in the comforts of routine until obligated to change. Healthcare delivery in America is no exception to this. The traditional manifestation of healthcare delivery has been a fee for service model. In this model, the health care provider is paid for each service rendered. An office visit, test, or procedure is compensated accordingly. Without constraint, this delivery model has
produced a reality that is truly fiscally unsustainable. Total health care spending in the United States is projected to climb to $4.8 trillion in 2021, up from $2.6 trillion in 2010 and $75 billion in 1970. To put this into context, healthcare spending will account for nearly 20 percent of gross domestic product (GDP), or one-fifth of the U.S. economy, by 2021*(Figure 2 and 3). Moreover, health expenditure per capita is almost 2 ½-times higher than in other Organization of Economic Cooperation and Development (OECD) nations (Figure 4). An argument can be made that unhindered healthcare expenditure is warranted if it parallels better outcomes; yet, with a mean life expectancy in the US of 78.7 years and ranked 26th in the world, this argument does not hold to fruition (Figure 5). One must inquire as it pertains to healthcare; why does the United States spend the most, but not deliver the best? A closer investigation of hospital-based care provides the ideal opportunity to resonate the importance of change management. Of total healthcare spending, a remarkable half (51%) goes to pay the cost of medical services provided by hospitals and physicians (Figure 6). When one takes an even more meticulous look, the forum of perioperative care is the principal culprit of expense, surmounting nearly 60% of all hospital costs.

The existing physician model does not curtail waste, redundancy, and inefficiency during the perioperative continuum. Rather, it is fragmented, with little care coordination of the patient1-3. Autonomous physicians practice with an individualistic, artisan like approach. Moreover, reimbursement is volume driven and there is little emphasis or

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Incentive for taking ownership of a patient; chaperoning him or her to recovery is not rewarded. Handoffs between care providers are numerous and poorly planned. Wasteful spending likely accounts for between one-third and one-half of all U.S. health care spending. PricewaterhouseCoopers calculates that up to $1.2 trillion, or half of all health care spending, is the result of waste. Preoperative evaluation is often inconsistent, with little consensus on appropriate consults and labs to consider. Postoperative care is disorganized, with no clinical pathways to minimize variability. This disarrayed care model does not succumb to the opportunity to impede numerous predictable complications. These anticipated and potentially avertable events include pneumonia, venous thromboembolism, acute myocardial infarction, decompensated heart failure, and wound infection.

While elucidating the dilemma of perioperative healthcare delivery has been easy, finding a sustainable solution has been a much more evasive endeavor. One solution to these issues is the recently developed Perioperative Surgical Home care model. The “PSH Care Model” is true innovation at its finest essence. By definition, it is a patient-centered, physician-led multidisciplinary, and team-based system of coordinated care. Via personalized and evidence based care plans, it guides the patient through the entire surgical experience and continuum from decision for the need for surgery to discharge from a medical facility and beyond. While autonomy for both the patient and practitioner

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is not hindered, ambiguity is clarified and addressed, fostering a forum for improved outcomes as defined by numerous metrics. The PSH model increases patient satisfaction, while reducing costs, complications, recovery times, and length of stay in the hospital. This perioperative care model – which refers to the period before, during and after surgery, spans the patient’s entire surgical experience, starting with the decision to have surgery through 30 to 90 days after hospital discharge. The Care Pathway is holistically mapped out by the medical professionals from the surgeons to the anesthesiologists to the nurses to the medical device specialists to the rehabilitation therapists, such that there is complete continuity of care as well as standardization of practices to enhance patient safety. UC Irvine Health anesthesiologists published numerous papers in Anesthesia & Analgesia, demonstrating the efficacy of the Perioperative Surgical Home for total hip and total knee replacements\textsuperscript{1,6,7}. The cornerstone of the Perioperative Surgical Home model is collaboration between all phases of the surgical episode with succinct handoffs or “transitions of care” between providers. Principles also at the forefront of the model include emphasis on diversified patient education tools, as well as thorough preparation for optimal clinical outcomes.

Indeed, the PSH is one resolution America has started to optimistically embrace as a solution to the imminent need for the dynamic evolution of healthcare delivery\textsuperscript{8}. The evidence guiding the need for change management is rampant; one could easily argue this is the “burning platform” in healthcare. Already perioperative specialists, anesthesiologists are blatantly in prime position to embellish in this unique prospect that has transpired. One must ask if the “jump” into the cold ocean that fundamentally
redefines the role of an anesthesiologist is worth the risk. Alternatively, one must ask if not taking the “jump” is the more perilous endeavor? Perhaps Abraham Lincoln said it best when saying, “the best way to predict the future is to create it.”
Summary:

- The “burning platform” is the ideal allegory to the insight that unless people are faced with a compelling reason to change, they will hold on to the status quo with tenacity, regardless of whether the status quo is perceived as positive or negative.
- Without constraint, the current model of healthcare in America has produced a reality that is truly fiscally unsustainable.
- The existing physician model does not curtail waste, redundancy, and inefficiency during the perioperative continuum. Rather, it is fragmented, with little care coordination of the patient.\(^1\text{-}^3\).
- As one potential solution, the “PSH Care Model” is a patient-centered, physician-led multidisciplinary, and team-based system of coordinated care.\(^1\text{-}^5\). Via personalized and evidence-based care plans, it guides the patient through the entire surgical experience and continuum from decision for the need for surgery to discharge from a medical facility and beyond.
- Already perioperative specialists, anesthesiologists are blatantly in prime position to embellish in this unique prospect that has transpired.
In July 1988, an explosion occurred on an oil rig off the coast of Scotland. The sole survivors were the ones that jumped into the frigid cold water below to await rescue. The “burning platform” is now a business lexicon that emphasizes immediate and radical change due to dire circumstances.

The U.S. spends nearly 20% of total GDP on Health Care, surpassing any other nation.
Figure 3 – The Rising Cost of Health Care in the U.S. in comparison to other Nations

U.S. Health expenditure as a % of GDP is rapidly trending up with a much steeper trajectory than other OECD nations.

Figure 4 - Health expenditure per capita in the U.S. compared to other Nations

Health expenditures per capita:
A global comparison, 2009

Health expenditure per capita in the U.S. is almost 2 ¼-times higher than in other OECD nations
Figure 5 – Mean Life expectancy in the U.S.

Note that the mean life expectancy in the U.S. is below several other nations, and lower than the OECD Average.
Of total healthcare spending, a remarkable half (51 percent) goes to pay the cost of medical services provided by hospitals and physicians.
References

2. ASA Committee on Future Models of Anesthesia Practice Annual Report to the HOD. August 18, 2013.

Suggested Reading:

“The perioperative surgical home: A comprehensive Literature Review for the American Society of Anesthesiologist.”